A. F. ASSOCIATES FAMILY MEDICINE, PC

PATIENT REGISTRATION FORM

Patient's Name: _____ **Date of Birth:** _____

Home Address: _____ **SS#:** _____

City: _____**State:** ___ **Zip:** _____ **Gender: M / F**

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Marital Status: (circle one) **Single Married Partnered Divorced Widowed**
Race: (circle one) **American Indian White/Caucasian African American Asian Other**_____
Language preference: _____

Responsible Party Name: _____ **Date of Birth:** _____

Home Address: _____ **SS#:** _____

City: _____ **State:** ____ **Zip:** _____ **Gender: M / F**

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Family Members (Currently covered by your insurance):

Spouse: _____**DOB:** _____ **SS#** _____

Child: _____**DOB:**_____

Child: _____**DOB:**_____

Child: _____**DOB:**_____

Child: _____**DOB:**_____

Primary Insurance:_____ **Policy#**_____

Ins. Co. Address: _____ **Group#**_____

City: _____ **State:**_____ **Zip**_____ **Phone#**_____

Policy Holder Name:_____ **DOB:**_____ **SS#**_____

Employer Name: _____ **Work#** _____

Occupation: _____**Full Time / Part Time (circle one)**

Secondary Insurance:_____ **Policy#** _____

Ins. Co. Address: _____ **Group#** _____

City: _____**State:**_____ **Zip:**_____ **Phone#** _____

Policy Holder Name:_____ **DOB**_____ **SS#** _____

Employer Name: _____ **Work #** _____

Occupation: _____ **Full Time / Part Time (circle one)**

Your Doctor: (check one) □ **Agerson** □ **Flood** □ **Johnson**

In Case of Emergency Contact:

Name: _____ **Relationship to patient:**_____

Home #:_____ **Cell #:**_____ **Work #:**_____

Please be prepared to present your insurance card at every visit so that we may verify the information we have on file. I hereby state that all of the above information is correct to the best of my knowledge.

Patient Signature: _____ **Date:** _____

Parent/Guardian if under 18 yrs.